DOCUMENT RESUME

ED 102 399 CE 003 127

TITLE	Home Health in Chinatown.
INSTITUTION	Health Services Administration (DHEW/PHS), Rockville, Md. Bureau of Community Health Services.
REPORT NO	DHEW-HSA-73-6408
PUB DATE	73
NOTE	37p.
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (Stock No. 1726-00033, $0.50)
EDRS PRICE	MF-$0.76 HC-$1.95 PLUS POSTAGE
DESCRIPTORS	*Chinese Americans; Chinese Culture; Community Agencies (Public); *Community Health Services; Cultural Factors; Culture Conflict; Educational Programs; Health Conditions; Health Needs; Health Occupations; Health Occupations Education; Health Services; *Home Health Aides; Language Handicaps; Non English Speaking; *Older Adults; Organizational Development; *Program Development; Special Health Problems

ABSTRACT

The document reports on the successful efforts of the San Francisco Home Health Service, which brings much needed homemaker/home health aide services to hundreds of elderly people in the San Francisco Chinatown area. Providing historical and cultural background information about the area, its residents, and its particular health problems, the report traces the program's development, which began with the cooperative efforts of the Self Help for the Elderly organization and the Chinese Hospital in 1966. The language barrier and lack of community acceptance were major obstacles in establishing the needed health service and a training unit for the preparation of homemaker/home health aides. However, an adapted homemaker/home health aide training program was initiated with the assistance of a three-member bilingual staff. Three case histories, chosen at random from the health service files, illustrate the type of problems encountered. An appraisal of the agency's ultimate acceptance by the community, its pattern of service, and major achievements close the report. (MW)

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HOME HEALTH
in
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In the preparation of this report, Cecilia Johnson, M.D. Health Officer of District IV, San Francisco, Department of Public Health, shared her long years of experience in the Chinatown area. Mr. Rudy Kao, who was employed as the first Chinese social worker during the important years in which home health services to Chinatown were planned and initiated, provided invaluable information concerning the history and culture of the San Francisco Chinese population and the methods used in gaining acceptance of the service. Mrs. Carolyn Chan, who was employed as the first Chinese nurse by the agency, and who offered the first training course for Chinese homemaker-home health aides, contributed valuable knowledge concerning Chinese attitudes toward health care and the methods used in implementing the delivery of health care aspects of the home health services. This report could not have presented an accurate account of extension of services to the Chinese population without their help.

DHEW PUBLICATION NO. HSA 73-6408

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 - Price: 50 cents
Stock Number 1726-00033

FOREWORD

The successful effort of the San Francisco Home Health Service, which brought much-needed homemaker-home health aide services to hundreds of elderly people in San Francisco's Chinatown area, is an inspiring example of what can be accomplished in the health care delivery field when local initiative and professional expertise are combined with strong community support.

The Bureau of Community Health Services believes that this illustration of the potential of in-home services—viewed not only as an alternative to costly institutional care but as an appropriate and indicated type of care—has vital significance for all concerned with long-term care throughout the country.

After years of searching for an effective way to expand its services into Chinatown (adjacent to an area already served), the San Francisco Home Health Service took advantage of the founding in 1966 of Self Help for the Elderly, an organization staffed by Chinese and located in the heart of Chinatown. Eventually, two-thirds of the home health agency's Chinese referrals came from this group. Simultaneously, the agency was fortunate in securing a bilingual social worker and a bilingual nurse. Under their leadership the language barrier, formerly impenetrable, was broken, and the program was successfully launched.

The language barrier—which represents a cultural barrier as well—exists in many inner-city areas of this country; if it can be overcome as completely as it was in this Chinatown Project, through patience, understanding, and a creative approach, then similar gains are possible everywhere.

The cooperation of Self Help for the Elderly and of the Chinese Hospital were essential to the program of the home health agency, clearly demonstrating the key contribution that existing indigenous institutions can make to the provision of in-home services in any area. It should be noted that the San Francisco Home Health Service began to aid Chinatown in response to special needs that community groups had long recognized and fully analyzed. Finally, the program remained flexible at all times, providing home health services to the fullest extent required and in a completely acceptable way.

PAUL B. BATALDEN, M.D.
Assistant Surgeon General
Acting Director,
Bureau of Community Health Services

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BACKGROUND

San F.ancisco's Chinese community has occupied a unique place in the city's history. The city has been characterized as "cosmopolitan." It has earned this reputation in part because of the variety of its self-contained enclaves, each representing different and unique aspects of language and culture: "Little Italy," "Rincon Hill" (old Russian Hill), "Japan Town," the rapidly growing Mexican community in the inner Mission, and later "White" Russian settlers in the inner Richmond; and the large post-World War II black community in the Western Addition and Hunters Point. For "old" San Franciscans, and in a different way for the tourist, Chinatown occupies a very special place. There have been Chinese in California since the period of settlement connected with the Gold Rush, and in San Francisco for almost as long. The port of San Francisco, often described as the "Gateway to the East," earned its title because it was the port of entry for the ships which brought tea, silk, spices, rice and other cargoes, the most important of which were human—the coolies who built the railroads, worked the mines, provided cheap labor as domestics, as laundry workers, as cooks, and as sweated workers in illegal manufacturing enterprises.

The glamour of Chinatown, the "core" territory of the city's Chinese population, represents, for tourist and old San Francisco resident alike, a melange of beautiful ladies, objets d'art, strange (and usually delicious) food, the fearfully exciting stories of tongs and tong wars, and the affectionate memories of long gone faithful houseboys. For the students of the 30s and 40s, it was the territory where they could eat and talk with their black friends when other community restaurants refused service, and where impoverished newlyweds could find interesting furniture, durable and lovely clothes, and sets of beautiful peasant ware—all inexpensive. The gilded balconies, the "temple," the theater, the quaint telephone exchange, the strangely haunting music, the narrow streets and the mysterious painted storefronts have been a part of the city's tourist industry for years. Willow

baskets of snails, tanks of live fish, groceries with shelves of oddly labeled bottles and cans, packages of candied coconut and ginger and fine spices have all been a part of the adventure, the facile use of chopsticks a mark of the "in" group of regular visitors. The loss of each landmark has been an occasion for regret for fond, non-Chinese residents of the city, a modern garage under Portsmouth Square, a towering and ugly motel (for tourists, not for Chinese), cocktail bars with pseudo-oriental facades, and millions of pseudo-oriental souvenirs at low prices.

Only the exterior of Chinatown has changed over the years. The constants—slum housing, exploitation, poverty with its serious health problems as an inevitable by-product—have remained.

Chinatown is a ghetto. Like those in all ghettos, which by their nature are enclosed, its inhabitants have been unable to participate in the life of the surrounding community. They have been unable to draw upon those community sources of help which have been available to others. It is a ghetto which, in some respects, differs from the ghettos of other racial and cultural groups. The enclosure system in other ghettos has almost invariably been imposed externally. This has been equally true of Chinatown. For the Chinese, however, there have also been strong internal influences which have, until very recently, held the Chinese to the "core" area of Chinatown, an area of a few city blocks. It is estimated that 37,235 Chinese live in the "core" area of Chinatown. With 1970 Census figures of 58,696 Chinese for the whole city, therefore, about 60 percent of the city's Chinese population is crowded into one-quarter of a square mile.

The external factors which have kept the Chinese in their ghetto are those usually found in any ghetto situation: protective covenants in other areas of the city, now illegal but still covertly operative; and the general scarcity of low cost housing which affects all low level economic groups (13,630, about one-third, of the population in the core area are classified as "poor"). Internal factors of language and culture have also acted as barriers to integration. These latter are perhaps far stronger among the Chinese than among other groups, for included in "culture" are the ties of clan and kinship which extend beyond the nuclear family and beyond the extended family as it is understood in western terms, to the clan—to all persons bearing the same name, to families originating in the same district of the homeland, to a set of complex interrelationships involving obligations, responsibilities, and ties based in long, firmly established tradition. These are by no means exclusively positive; they involve, as well as certain aspects of protection, the imposition of restrictions and hardship. San Francisco Chinatown is a central and important community for the Chinese population of the United States, the headquarters of the Six Companies and of similar organizations and associations which exercise considerable control over the lives of the population—over employment for Chinese-speaking workers, over a good deal of the available housing; over business

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Shopping

and employment. They are internal organisms which operate protective enterprises; they act in a legal capacity for the Chinese-speaking population and, until recently, were the major resource for the immigrant as well as the old resident in most situations: those involving adjustment to a new country, earning a living, maintaining a family, managing in a world in which virtually every aspect of life is vastly different and largely incomprehensible. Language for the Chinese population has been a difficult, almost insurmountable barrier to the outside world, and, until very recently, one which has received virtually no attention from the host community. If Chinese have "preferred" to live in Chinatown, where familiar food and familiar language have to some extent eased the transition for the immigrant and provided a kind of security for the old residents, that preference has been reinforced by some very practical necessities.

In this difficult and complex situation the most significant factor is related to the bizarre history of our immigration laws with respect to the Chinese. Loopholes in the Exclusion Acts and in subsequent legislation—specifically those which permitted the right to confer derivative citizenship upon the alien born offspring of American Chinese citizens, in the face of the restrictive

quotas—have produced a situation in which many Chinese came into the country by falsifying their names and their relationships to Chinese-American citizens. Chinese males who came to the United States traditionally returned to their families in China to visit. These visits were frequently followed by the declaration that children had been conceived in China. Later, these children were permitted to enter the United States as offspring of American citizens. The fear of discovery when the relationship was falsified has affected families and their offspring here and has led to a general unwillingness to come into contact with those outside the Chinese community. Since these arrangements most frequently were paid for, either through the acceptance of long term indebtedness or through repayment in terms of labor, a form of internal control has existed over an unknown but probably sizable group of Chinese. The fear of all outside intervention, even when it is intended to be helpful, has been a powerful factor in maintaining the inward pull of the Chinese community. More recently this has been complicated by the increased immigration which followed the Immigration and Nationality Act of 1965, and by considerable division in political and social attitudes; between the "old" Chinese, with their ties to the traditions and customs of a homeland which no longer exists, and the new young generations of American-born Chinese; between the identification of the "establishment" with Nationalist China and the identification of young American-born Chinese with the country of their birth. It is to a large extent this latter group which has begun to open Chinatown to the services and facilities so badly needed for its population.

The Population

Precise data concerning the composition of the Chinese population is not available for the "core" area. Most data include that section of the Chinese population, usually American-born with young families, which have moved into the inner Richmond. Population statistics from the 1970 census and other sources indicate that in Public Health District IV (which includes the adjacent Italian North Beach community) there are approximately 18,470 persons under the age of 21 (4 percent receiving AFDC payments). Surveys by Planned Parenthood of the Chinatown population indicate that long-term resident families have tended to be small in number. Immigrant families, however, have averaged about seven persons.

With respect to the elderly, more specific data are available. The San Francisco Department of Public Health Annual Report for 1970 estimates the over-65 population at 20,057, nearly 5,000 elderly are over 75, and the district health officer reports that there are 92 individuals in the district over the age of 100. It is estimated that there are between 8,000 and 10,000 elderly poor in the Chinatown area. Approximately 7 to 9 percent of the immigrants entering between 1965 and 1969 were 60 years or older. Roughly 380 to 500 elderly moved into Chinatown during this period.

There is a reversal in this population as compared with the rest of the community: men outnumber women; the single elderly male predominates. This follows the immigration pattern: the importation of male laborers; the immigration of males intending to establish themselves before bringing their families, or to return to their families in China when their working days were over; selective preference in immigration laws (i.e., the seven "preferred" categories which placed merchants and professionals, usually men, high on the list).

Housing and Health

It would be impossible to list the problems generated by this densely populated community in the order of their importance; they are interrelated. Housing, if not first in importance, is certainly responsible for many of the problems that profoundly affect the community. The word "cubicle" is commonly used to describe this housing. Tenements in which single rooms house eight or nine persons, rooming houses in which living space is divided into boxlike units with a single kitchen and single bathroom to serve a three- or four-story building; families packed like sardines into unventilated, poorly lit, closet-like living space. This is the general rule in Chinatown. The 1960 census indicated that over one-half of the available housing units in the area were one-room units (the total number of units for the area was 28,548). Still, housing is expensive. Rents for a single unit were listed in a 1970 survey of 56 households at $80, rents for three-room units, housing three to nine persons, ranged from $86 to $220. The waiting list of the San Francisco Housing Authority lists 1,075 applicants for housing, of which one-third are for single elderly persons, one-third are for two-person elderly households, 30 are for elderly heads of families requiring two to four bedrooms (probably disabled heads of households), and 400 are for non-elderly households. The Ping Yuen housing projects, built in 1958 and 1969 housing 428 families, have barely touched the surface of Chinatown's housing needs.

Chinatown has always had a high incidence of tuberculosis (three times as high as the rest of the community); malnutrition with its associated problems is prevalent, the result of a combination of poverty, cultural food habits with low protein consumption, avoidance of milk and dairy products (among immigrants particularly), and the use of polished rice as a staple. Neither infant mortality nor maternal mortality are high, but the 1971 death rate for the district was 17.2 as compared with 12.0 for San Francisco as a whole. District IV has the highest death rate and the second largest number of deaths. Venereal disease rates are substantially higher (gonorrhea 2,376.0 per 100,000 as compared with 1,642.3 in the general population; syphilis 289.5 per 100,000 as compared with 173.8). The incidence of chronic disease in diagnostic categories related to aging is understandably high.

The incidence of mental illness and emotional difficulty is very high. The stereotype of the calm, unemotional oriental does not prevail. Fear, the conflict between the "old" culture and the new environment, between the young and the old, the pressures engendered by crowded living, depressed working conditions, complex controls related to the roles and functions of the traditional organizations which have acted as interpreters of the surrounding culture—all these factors produce depression, paranoia, and a host of bizarre behavior patterns, as expressions of the unequal struggle to make even a minimal life adjustment.

Community Services Available to the Chinese Population

Prior to 1965 community services available to the Chinese population were limited to the two major public services—the Health Department and the Department of Social Services—and to services provided by church groups, usually social and educational, with sporadic services from voluntary agencies outside the Chinese community. The Chinese Hospital, located in Chinatown, had no out-patient department and, although some younger families went outside the area to out-patient clinics of the various community hospitals, older residents and immigrants tended to use only traditional sources of health care: herbalists and those Chinese physicians located within the area. International Institute, located outside Chinatown, offered limited services to immigrants.

The powerful influence of the various Chinese organizations tended to foster the belief that the Chinese had their own effective methods of caring for the needs of the population. To some extent this has been true. Chinese schools funded by these organizations kept language and customs alive; it is estimated that more than half of the housing is owned by these organizations, and the prevalence of Chinese-owned power machine shops, which provide a good deal of the employment in the area, led to the comfortable conclusion that the Chinese community was self-sufficient.

With the changes in the immigration laws, however, this comfortable conclusion could no longer be sustained. Most Chinese newcomers to the United States, entering either legally or illegally, came to San Francisco. During 1971, for example, about 14,000 Chinese entered the United States. It is estimated that one-fourth of these stayed in San Francisco, most of them preferring to remain in Chinatown. Health, houring, and educational facilities were (and are) unequal to these pressures.

The Elderly in Chinatown

For the 10,000 elderly Chinese in Chinatown, particularly the elderly poor, the story has been one of pain, deprivation, fear, and bitterness. Life in Chinatown has been a marginal existence of disease and dependency under the worst possible living conditions.

家庭健康服務員

Home making · Home Health Aide

The San Francisco Home Health Service
(formerly The San Francisco Homemaker Service)

The San Francisco Home Health Service was established in 1957 as a homemaker agency emphasizing services to the aging population. While it was intended as a resource for the whole population, about 90 percent of its services were utilized by aged poor and marginal income groups. The agency's initial objective, to provide elderly individuals with simple homemaker services (i.e., shopping, cooking, environmental maintenance) for short periods of time, proved unrealistic because of the nature of the need.

By the end of the first six months a picture of need emerged which was to remain constant over the next ten years and was to be reflected by other agencies across the country whenever similar services to adults were offered. First, of course, was the emphatic evidence of the vastly under estimated numbers of those in need. At the end of the first six-month period, applications for service had more than tripled. It continued to rise over the years, has never "leveled off," and at no time in the agency's history was the agency able to accept more than one-third of these applications.

Most important to future planning was the nature of the need. The "well-aged" individual in need of supplementary assistance did not appear in significant numbers. The problem clearly existed as one primarily generated by the presence of serious chronic disease with heart disease, cancer, stroke, and diseases of the bones and joints heading the list, often in combination with other illness (i.e., diabetes, defects of vision). The supporting family which was presumed to exist, did not, in an age group in which the median age was in the 70's with almost one-fourth of the group over the age of 80.

In the total group, women outnumbered men substantially; about two-thirds of these women lived alone (half of the applications from men were also from those who were alone). Where a family group did exist, other family members were often also advanced in age and diagnostically fitted into the same categories of chronic disease in approximately the same proportions as those described for the referred applicants. Additionally, there were in the group a substantial number of individuals whose need was not short-term and therefore did not terminate conveniently.

These were the truly chronic patients whose intensity of need fluctuated from day to day or week to week. With assistance ranging from part-time and minimal help to more concentrated care they could be maintained at home for long periods of time—even for years as it developed. Termination of service often meant rapid deterioration and institutional placement. They could not be considered as candidates for institutional care since home care plans could be perfectly feasible as long as supervision and the necessary assistance was adapted to current need. Once the plan was made it became impossible for the agency to terminate service in view of the clear consequences.

By the end of the first year a standard of eligibility had been worked out. The service was available (to the extent that funds were provided for service) to those who, because of chronic illness, could be feasibly maintained at home with agency supervision. "Feasibility" was determined by a variety of factors: selection of the home care plan by the patient as a matter of choice, availability of medical supervision, ability to maintain the plan with part-time assistance (except in emergencies or periods of very limited duration). Neither the presence of a "responsible relative" nor the projection of time-limited services were eligibility factors. The chronically ill adult in need of in-home assistance is at least semi-ambulatory and semi-housebound. If he were not, he would not need this type of assistance. The delivery of medical services in the home has diminished steadily and the extension of clinic services into the home is relatively rare. But more than this, the assumption that the private physician or the clinic is in a position to

assemble and coordinate necessary community follow-up is, to say the least, an unreasonable expectation. The source of medical care is in a position, ideally, to indicate the services needed and to direct them and this is where the confusion arises when the physician is designated as the "team leader" or the "coordinator." There must first be a "team" available to him; a team which, for the chronically ill patient, is by policy dedicated to long-term service and which has available both the knowledge of what exists in the community and the physical resources to bring them into play in the fluctuating pattern of need which is present in long-term illness.[1]

In order to provide the array of services which might effectively meet the needs of this population, the agency attempted first a cooperative program with the county Department of Public Health in a demonstration funded by the Office of Long-Term Care Services, Community Health Services, Health Services and Mental Health Administration. When this approach could not be maintained, the Homemaker Agency moved quickly to the development of an independent Home Health Service, offering in addition to the services of homemaker-home health aides, nursing services, social services, physical and occupational therapy, (contract services) and, intermittently, meals-on-wheels, provided through arrangement with an independent but cooperating service. The federally funded project initially stimulated staff awareness of the needs of the Chinese population. When key areas of the community in need of extended services were identified, the situation in Chinatown was repeatedly stressed by the staff of the health center in District IV and the need for special planning was accepted by the agency.

The Agency Reaching Out to The Chinatown Area

Between 1957 and 1965 there were three referrals of Chinese patients to the agency. One from the outer Richmond was a request for short-term care and, since there was no language problem the service was provided. The other two were from the Chinatown area, and in both instances the requests were initiated either by the patient or family members. Attempts to set up planning visits proved unsuccessful, both because of language problems and because efforts to find a way to offer help were rejected. During the first six months of 1965 only one referral of a Chinese patient was received. This time a volunteer interpreter was found, but service was again rejected.

The agency from its inception provided considerable service to the Italian population on the borders of Chinatown, and since agency staff worked closely with the staff of the District IV Health Center, there were continued discussions of the problems in the Chinatown area which increased steadily. The problems of aging and chronic illness in the "old" population

[1] *Home Health Services and Public Health*, Final Demonstration Project Report. San Francisco Home Health Service, February 1969.

and the complex problems of greatly increased numbers of new immigrants caused concern and a sense of frustration. Consistently, discussions pointed to several major obstacles to home health services in the Chinatown area. The first of these was language. The agency had met the needs of various non-English speaking groups, employing homemakers who spoke Russian, German, Spanish, and, at various times, workers who could meet other language needs. These situations, however, had one thing in common: all employees were *bilingual*. Supervision, reporting and recording did not present significant problems. Nor in the groups served was there great disparity in customs or in attitudes toward health care.

> Particularly the problems of the Chinese have received a great deal of attention over the past few years. The senior citizens of this group have experienced lifelong isolation from the mainstream of American life. Almost unsurmountable difficulties in learning English, lack of education, low paying jobs and a general foreignness contribute to this state of affairs. In addition, many of them have limited knowledge of western medicine and use it only in extreme crisis. They might neglect their health care in our way of looking at it. When they finally seek help, hospitalization or placement in a nursing home might present the only alternative. But because of the advanced stage of the illness it might prove of little help. When these patients die in the hospital or nursing home they set a fearful precedent for their friends. Hospital or nursing home becomes synonymous with death. It contributes to their reluctance to seek western medical help at an early stage. Death away from home is not desirable. The cultural heritage demands that "a person die in his familiar surroundings in order that his ghost will not get lost and wander about."[2]

Here it must be pointed out that the provision of services in the home differs considerably from other community services with respect to the need for communication. The occasional visit to a social agency, a physician's office or a clinic can be dealt with, if not well, at least with a possibility of a minimal exchange, or through an interpreter. This is not possible when the services needed involve the activities of daily living: the need to communicate on a continuing basis concerning both the minutiae of daily life and more basic issues of a central health problem.

Late in 1965 the agency developed a relationship with one of the church groups, Cameron House, and what appeared to be a hopeful beginning was made. Cameron House, an established institution in Chinatown for many years, financed by the board of National Missions of the United Presbyterian Church, provided a center for club and recreation activities

[2] *Statement of a Problem*. Chinatown-North Beach Health Care Planning and Development Corporation, February 1972.

言語療治專家服務

Speech Therapy

for boys and girls and had developed some adult study groups and a tutoring program. This was a period when there was a good deal of emphasis upon educational remediation for various ethnic groups in the community and the prospect of drawing personnel with even limited English from this program appeared encouraging. A referral was received from Ping Yuen, the housing project in Chinatown. This referral appeared to be feasible for home care except for language. The referred patient was a single man with an acute cardiac problem. Neighbors helped the agency worker with the initial assessment, and, for the first time, it appeared that the service would be acceptable. With this referral as its focus, the agency's social work supervisor approached Cameron House. In the group at Cameron House one bilingual Chinese woman was located. She was a woman of charm and considerable intelligence, had been well educated in China, and was willing to try to work as a homemaker. She received on-the-job training and remained the only Chinese staff member for a year, providing service to the occasional Chinese referrals as well as to Italian referrals from the North Beach area.

Although increased referrals were not numerically impressive, agency

staff continued to learn about the need for service through its contacts with the health center. The community's awareness increased as well, and in 1966 the agency made a determined effort to develop a Chinese-speaking staff of homemakers, through which aggressive case finding might be established. Cameron House collected a group of Chinese women who expressed interest in the work. This willingness was significant. Along with the language difficulty there had been a prevalent impression that Chinese women would be reluctant to accept employment of this kind because of the personal aspects of the work. Arrangements were made for a meeting between the social work supervisor and this group, with an interpreter provided by Cameron House to assist with initial explanations. When the agency worker arrived she did indeed find ten smiling, attractive women, willing and cordial. The interpreter, however, was unable to come and it was evident that none of the women had the minimal bilingual facility which would be essential for training and supervision. Worker and prospective applicants smiled and parted. But the impression remained that there was indeed a potential staff in Chinatown if only the language barrier could be breached. It should be pointed out that this situation was not unique. For many years well baby conferences had been provided by one Chinese-speaking non-Chinese physician, and in the years prior to this effort Northeast Health Center relied on a single Chinese nurse. The situation did not appear hopeful.

But 1966 was the year of significant development for the Chinese service in the agency. The agency had continued to hope that it could serve the Chinese population by adding *bilingual* Chinese homemakers to the staff, integrating these workers with the regular staff, and using the supervisory skills of the existing professional staff. Because of limited funds available and the relatively small Chinese caseload which was anticipated, this appeared to be the only feasible approach.

The desire to maintain an integrated staff was based upon considerations which were more important than those of economy. The agency had, from the beginning, stressed something more than a structured "team" approach to service. Homemakers and professional staff shared experiences on a continuous basis. Cases were discussed in general sessions, at lunch, in individual conferences. Virtually every staff member was familiar with the circumstances of individuals receiving services and could move and shift with a minimum of difficulty. The agency's policies were strongly related to a particular set of skills and, more important, of attitudes which enhanced comfort and security, which encouraged flexibility and autonomy. A great deal of effort had been invested in developing the warmth, the objectivity, the acumen in making observations, the capacity to give and take supervision comfortably. Existing bilingual staff had shared with other staff members their knowledge of the customs, the culture, and the special needs of the groups they served, enriching the entire staff and enlarging the scope of their capabilities.

Altering this approach for the Chinese population appeared threatening to this atmosphere. There was concern that the agency might be, in effect, establishing an island within its walls; that administration and supervision would be difficult at best; and that some of the essential quality of the services might be lost to the Chinese population. At this point, however, it was apparent that there was really no possibility that remedial and tutorial efforts were going to produce potential bilingual Chinese workers in sufficient numbers to serve even a limited Chinese caseload.

The practical solution to the problem was obvious. If bilingual *supervision* could be found, homemakers (and later home health aides) need not be bilingual. The agency would rely on the quality of the bilingual supervisor to transmit to Chinese homemakers the special qualities essential to the services and to undertake the task of educating the agency staff to the needs of the Chinese group served.

Late in 1966 the Chinese vocational counselor at the California Department of Human Resources (then the California Department of Employment) referred a young applicant to the agency. He had returned to San Francisco after a period as a social work assistant and later as a social worker in the Public Welfare Department of a Northern California county. He had had a year of graduate social work in a State college. He had worked in San Francisco initially as an interpreter in one of the social agencies. The dean of the graduate school recommended that he have a period of employment before returning to graduate school, noting that he "hadn't absorbed American values." He had lived most of his life in China and spoke six Chinese dialects, an advantage which the agency would not appreciate until a good deal later. He spoke fluent English and made an excellent impression on the agency supervisor. Whether or not he had at that time "absorbed American values," he subsequently displayed a deep dedication to his people, coupled with a profound knowledge of the problems of the Chinese in Chinatown and the complicated situation in which they lived. He was employed as the social worker for District IV, with combined responsibility for the Chinese and Italian cases. A second Chinese homemaker (non-English speaking) was employed, and this group—one social worker, two Chinese homemakers, and eight non-Chinese homemakers— made up the district staff. The agency was now in a position to extend its services into Chinatown.

Important changes occurred in 1966, for the agency and for Chinatown as well. Within the agency the need for health services had become pressing. The caseload was made up almost entirely of chronically ill adults, 20 percent of them over the age of 80 and almost all with major chronic disabilities. These facts, combined with the termination of the health center project which had provided nursing supervision and an emphasis upon health orientation in staff and services, made the next step in policy a foregone conclusion. A nursing staff, begun late in 1964, had increased gradually. In 1966 an

adequate ratio of nurses to caseload was achieved. Meals-on-wheels was already available through the Women's Auxiliary of the County Medical Society. Nutrition services and, under contract, occupational therapy, physical therapy, and speech therapy services were added. (The agency subsequently applied for and received certification as a home health agency under Medicare.)

Homemakers in the agency had for some time been trained to provide "personal care"—essentially the same services described as appropriate to a new category of worker, the "home health aide." Development of such "polyvalent" paraprofessionals, who could combine environmental and personal support with specific health related services (bathing, transfer activities, assistance with ambulation, etc.) was implemented through the development of a training program. A training grant was obtained for this purpose. It was significant for services to the Chinese population because of a simultaneous decision to develop and implement a training program specially geared to Chinese homemaker-home health aides and to the special needs of the population they would serve. Although this might have appeared optimistic in terms of the very small number of referrals which had been received, a second development encouraged the agency to invest heavily in training for an anticipated rapid increase in Chinese referrals. This was the establishment of a new "internal" Chinese agency with funds from the Economic Opportunity Committee. Self Help for the Elderly, located in Chinatown, was organized in 1966. Its functions were: 'Providing social casework and counselling, housing and relocation, employment services, portable meals program and referral services. Serving people over 45."

For this agency the prospect of in-home services geared to elderly Chinese offered an important resource. It appeared evident that referrals were going to increase because of the presence of Self Help, staffed by Chinese and situated in the core area of the Chinese population. Subsequent experience supported this expectation. More than two-thirds of the home health agency's Chinese referrals were to come from Self Help.

The establishment of a separate training unit for Chinese paraprofessionals involved, first of all, the conversion of the standard training program for homemaker-home health aides. This was not simply a translation, although selected materials for both workers and anticipated consumers of service were prepared in Chinese. The adaptation of these materials so that the essential principles and purposes of the services would be understood and accepted by groups whose cultural patterns differed in essential aspects was the most important element in this effort. Goals in service for the general agency population involved the usual combination of assessment, establishment of a treatment plan, and implementation of the plan with services directed toward maximum rehabilitation. Goals for the Chinese population involved (1) interpretation of the positive values of western medical care, (2) establishment of an acceptable channel of medical supervision, (3) re-

社會工作服務

Social Work

structuring nutritional and living patterns, (4) interpreting personal care, to many Chinese an unacceptable form of care, and (5) developing and supporting channels to available community resources.

Setting up a new unit involved location of a training site which would be adapted to the special needs of trainees, preferably in Chinatown, and preferably in a health setting or something close to it. It involved Chinese-speaking faculty, necessarily bilingual, since a key element in training is close identification with agency philosophy, policy, and services. It involved recruitment of trainees with personal warmth, tolerance, judgment, the capacity to adapt to widely differing situations, and interest in and aptitude for the acquisition of specialized and varied knowledge and skill.

Although the agency anticipated difficulty, it quickly located a training site and acquired a bilingual faculty. Chinese Hospital, a tax-exempt proprietary hospital in Chinatown with a staff of both Chinese and Caucasian physicians, had not previously developed strong relationships with community agencies. It had no outpatient department and served mostly the middle class and affluent Chinese population. With the increased pressures within Chinatown; a corresponding increase in self-consciousness in the Chinese community

concerning its problems and the need for internal effort began to develop. This, together with the infusion of new interest in the form of young community-minded physicians, affected most of the traditional institutions, including Chinese Hospital. It became the site of the homemaker-home health aide training program in Chinatown, and its personnel and facilities, adapted to its special community, proved invaluable.

Considering the dearth of bilingual professional staff, core faculty was obtained with surprising ease. For orientation, agency policy, and the interpersonal, or growth and development sequence, the new agency social worker functioned as faculty.

A bilingual Chinese nurse was found in Chinese Hospital. She was quite young and somewhat fearful of the teaching responsibility, but, like the social worker, she had been born in China and had herself experienced the transitional problems of the Chinese in Chinatown. She had a deep identification with them and a very real understanding of their needs. She had a special interest in providing care at home. Following the termination of the training project she became nurse-supervisor in the agency's Chinese unit.

A third bilingual faculty member was the agency's nutritionist. The fact that she was Chinese and bilingual was simply fortuitous; the position of nutritionist was open and she applied. She developed nutrition materials in English for the general staff and in Chinese for the unit where she functioned as consultant in the development of general and specialized skill in nutrition.

This staff, under the general supervision of the agency's training director, began the work of adaptation and training.

The Adapted Training Program

The Standard homemaker-home health aide training program stresses:

1. The meaning of organized versus individual service, and the responsibilities related to organized services.
2. Services policies which protect both the recipient of services and the worker: adherence to the assigned plan of service, to assigned hours; identification of common problems with respect to requests for unusual service or activities which are unsafe; observation skills; the effective use of supervision, especially when unusual situations arise; and, of course, agency personnel policies.
3. Understanding behavior in terms of both insight for the worker and factors in personal development, and in individual circumstances which produce varied individual response. The development of tolerance, acceptance, and supportive responses.
4. Skills.

   Homemaker-home health aide skills stress the maintenance of a safe, health environment, the provision of good food well prepared (includ-

ing, of course, general and specialized nutritional needs), interpersonal support and the maintenance or restoration, as far as possible, of a normal way of life, or at least the recovery of maximum security of the individual in his personal environment. They also include skills which are specific to the treatment plan for the particular health problems of the individual served, mostly those involving the activities of daily living: bathing, shampooing, shaving, dressing, ambulation, development of maximum independence.

5. Observations of physical change, temperature, pulse and respiration, special problems, and carefully delineated occupational and physical therapy activities are also included. Careful adherence to assigned tasks and use of supervision are stressed throughout.

For some Chinese trainees, adaptation of this training content presented some special problems in recruitment, selection, and later in supervision.

Typically, agency homemakers (and later homemaker-home health aides) were drawn from the city's population of unskilled workers (about 73 percent of those employed had at some time received public assistance). What might be described as a "set" in recruitment and in employment attitudes had been established. White collar workers had not worked out well as a rule; they were poorly adapted to the manual (frequently considered "menial") skills required. Usually trainees drawn from the white collar group expected to limit themselves to aspects of the work more clearly identified with friendly visiting.

In Chinatown, however, there were women working at power machines in sewing factories, as janitors, in restaurants as kitchen helpers, as occasional baby sitters, who had been trained in China as nurses or accountants, who had worked in professions and in managerial capacities. They had had considerably more education than most of our aides. Many of them came from a milieu which could clearly be defined as middle and upper-middle class. The language barrier was their basic limitation. The realization that such personnel were available came after a channel of communication was established through Cameron House; but reservations about the usefulness and adaptability of these women were overcome only with experience. In all, 23 Chinese women were trained as homemaker-home health aides in the program. Not all of them stayed the course; some subsequently left for personal reasons (never because of expressed dissatisfaction with the work, usually because of a change in their housing locale). At its peak there were 17 effective Chinese homemaker-home health aides working in the unit.[3]

Only two were bilingual. (The first worker, hired prior to the initiation of the training program, became the telephone intake worker in the Chinese

[3] There was a substantial staff reduction throughout the agency because of funding problems in 1969, and another in 1971. Chinese staff was correspondingly reduced.

unit.) Personnel records with respect to previous background were not always completed, but for those who provided the essential information, five had been trained and had been employed as registered nurses in Hong Kong; one had been the wife of a pediatrician (now deceased) in Hong Kong; one had been trained and had been employed as an accountant in Hong Kong; one had worked for years as a buyer in a large Hong Kong department store; four were high school graduates; only two recorded education as grammar school only. Several spoke more than one Chinese dialect.

It was evident that adaptation of training content for this group need not necessarily be in the direction of simplification, particularly since language presented no problems. It was anticipated that the areas of stress in training content would be in three directions: in adherence to the treatment plan—particularly as it related to reliance on supervision rather than independent action; in tolerance for, and acceptance of, individuals of different social and educational background in need of services, particularly personal services, and in developing ingenuity and skill in introducing "western" methods of care to a previously closed group.

During orientation period the concept of the agency, of organized services, and the nature of this responsibility as it differs from individual effort was emphasized. This area required considerable reemphasis in the course of supervision. Difficulties, when they did arise, were rarely related to independent changes in the care plan, particularly with respect to personal care. In this respect, the group differed from the "general" staff of homemaker-home health aides in which staff did occassionally fail to understand the importance of scrupulous adherence to medically established orders. The group as a whole adapted easily to the personal care skills taught in the hospital setting and these were, in general, carried over to the independent situation in the home with considerable ease. In one very complicated stroke case the physician noted:

"Much of the credit (for the patient's recovery) should go to . . . the Homemaker-Home Health Aide . . . who followed a very structured and extensive daily program of physical activity and exercise." The record also shows the building of confidence in a fearful patient through the development of a relationship between the homemaker-home health aide and the patient that was subtle, delicate and yet very strong—a key factor, really, in the recovery.

Those areas requiring the greatest emphasis were related to a rather unusual problem; the problem of gaining acceptance of the services by the recipient and, less frequently, the problem of the use of authority by the worker. In the first instance both "class" and the fact that workers were all women presented some difficulty. It might be expected that workers, most of them in the middle-class category, might have experienced some reluctance in accepting the kinds of personal and environmental tasks assigned to them.

個人護理

Personal Care

This was rarely the case. But the elderly, often impoverished recipient of services frequently found it very difficult to accept such services from Chinese, particularly from those workers who were from a different social level. Workers often needed a great deal of support from the professional staff to effectively interpret their services as natural to their activities, as aspects of professional care. There was also the cultural barrier on the part of male recipients—and men made up a large percentage of the caseload—with respect to personal care provided by women. Again, the homemakers adapted readily to the task of providing these services; their persuasive powers, however, were stringently tested. The "authoritative" approach in implementing care plans sometimes required tempering by the professional staff. The fact that care had been prescribed and would be beneficial appeared, sometimes, to be a good reason for imposing it, rather than working toward acceptance through understanding the patient. (Achievement in this area was probably less difficult for this staff than for others with this same problem)

One of the most difficult problems to meet, one that could not be attributed to the cultural background of the workers, was the fact that

psychological and emotional problems were frequently encountered. Profound depression ("he says he eats the bread of bitterness"), hysteria ("she cries suddenly"), and the more bizarre aspects of paranoia, are referred to repeatedly in the records. Patient reassurance took up a large part of the time spent in the "home," if many of the miserable cubicles could be so described. Workers initially had considerable difficulty with manifestations of paranoia. Psychological services were available in the health center, but most of the patients served by the agency were elderly and so fearful that they would not venture out-of-doors. It is interesting to note, both in records and in case conferences, the practical approach to these manifestations which was adopted by the staff, with guidance from the social worker. One homemaker patiently and repeatedly took a patient upstairs to see that her neighbor had *not* bored a hole in the ceiling to spy on her (patient and neighbor subsequently became friends, though occasionally the "hole" reappeared); other similar demonstrations of reality occurred, sometimes daily, sometimes hourly, and occasionally with good, if not sustained effect. Fearfulness on the part of staff when such manifestations were encountered disappeared. It was stressed always that more serious manifestations must be immediately reported.

The Unit in the Chinatown Core Area

Beginning in 1966, changes were made in the agency structure which greatly accelerated the development of services to the Chinese population. The agency experienced a period of rapid growth, with increased caseload and the need for increased staff. There was also an increased awareness of the need to become more intimately involved with neighborhoods, particularly those with ethnic populations. The decision to decentralize services and to establish district offices was particularly effective for Chinatown, with its tight inward cultural pattern. In 1967, with a staff of 27, the agency opened a district office in the heart of Chinatown.[4] It served both Chinatown and the North Beach area with a mixed staff, but the staff was predominantly Chinese and the telephone intake was manned by a bilingual Chinese. (Telephone intake is a key post in all home health agencies, since more than 90 percent of referrals are received by telephone; adult service consumers are rarely ambulatory out of doors and frequently are without family.)

After almost ten years of agency operation with virtually no service to the Chinese population, "outreach" had taken the form of community integration. Chinatown now had its own home health services.

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[4] This office was maintaining for four years. It was reintegrated along with other district offices in 1970. By that time the physical location had become unimportant. The services were accepted and used to the fullest extent possible.

CASE HISTORIES

The following case summaries have been chosen at random from the files of the San Francisco Home Health Service.

Mr. F. H. C.

This 73 year-old man was referred in late 1967 by Self Help for the Elderly. He had been receiving Aid to the Totally Disabled and was transferred to OAS. He was living in a typical Chinese single man's unit, a cubicle of his own, with bath and toilet shared with a large group of similarly-placed single men.

He was blind and diabetic. He had had numerous eye surgeries and had become almost totally blind about a year prior to the referral. He had just received an eviction notice because of the filthy condition of his living unit and because of his surly attitude. He was described as a profoundly depressed recluse. He was receiving periodic check-up visits from a nurse who sterilized syringes and needles for him for self administration of insulin.

At the first visit Mr. C. was found in an unbelievably filthy room covered with dust and dead cockroaches. He was extremely resistant to the idea of any kind of help. The nurse said that he was harsh, cynical and bitter. He said he felt he was in prison. Occasionally, he used a hot plate in his room for warming up canned food and the rest of the time, if someone brought it, he ate restaurant food. He made no effort to follow his diet. He had been given a contact lens for one eye following his surgery, but had never been taught to use it.

The care plan involved: regular homemaker-home health aide services to maintain his room, to shop, cook and maintain his diet, to assist with bathing, to reestablish medical supervision, particularly with his ophthalmologist, and to encourage walking, particularly out of doors. He was at first extremely resistant to any help, but the homemaker-home health aide arrived consistently and worked to achieve acceptance. A nutritionist was brought in to establish some kind of rational approach to diet. Although Mr. C stated that he never bathed and used his basin for washing, the condition of his scalp and skin were such that a tub bath was essential, but he absolutely refused this kind of assistance. The homemaker-home health aide, toward the end of the first month of service said, "He is very timid. He does not want personal care at this time."

Seven months later the nurse reported that Mr. C's appearance was "much better although he cannot keep to his diet." With medical supervision resumed, he was taught to use and care for his contact lens, he was able to see color and certain outlines with one eye, he was given a cane but was still reluctant to go out.

He was having much difficulty with his public assistance checks; a Chinese field service worker was assigned to see that these were cashed.

His personal hygiene was much improved; he had accepted assistance from the homemaker-home health aide, including help with shaving and care of his scalp.

He had developed an excellent relationship with both the aide and field service worker, and when his brother, who lived in another community, died and he became extremely depressed, he accepted assistance from the social worker.

By 1970 Mr. C was going out. With the assistance of the field service worker, he was able to go to the barber shop and to the ophthalmologist. Twice a week he visited a friend who lived several blocks away and enjoyed the visits very much. He had become more cheerful, was described as "better looking," and finally accepted assistance with tub bathing. He still has considerable difficulty maintaining his diet.

Service is still active and will undoubtedly continue, although the frequency of service which was begun on a daily basis has been reduced.

Mrs. S. H. C.

This 88 year-old woman was referred to the service by Self Help for the Elderly. The presenting diagnosis was rheumatoid arthritis, but, following admission to the service and reestablishment of medical care, there was added to this diagnosis arteriosclerotic heart disease and toxic goiter.

This elderly woman with bound feet was living alone in a cubicle room, attempting to use the community bath and toilet in the building. Her husband, who had been a farm laborer, had died some years previously, and she moved to Chinatown following his death. She received public assistance. A married daughter who does not live in San Francisco visits her once a month in order to clean her apartment.

Although the diagnosis was not added, it was apparent that she suffered from paranoia. She was extremely fearful, thought her neighbors were trying to annoy her so that she would move away, thought that they were spying on her through the walls; because of her fears, she lived as a recluse.

Her physical difficulties in using bathing and toilet facilities, because of the condition of her feet, were considerable. The community bath was an impossibility, and she had been attempting sponge bathing.

When medical care was initially proposed, she refused but was later persuaded to accept a physician's services. The doctor prescribed a low-salt diet and medication. He recommended personal care, bathing and shampooing, and suggested that every effort be made to reassure her because of her evident fearfulness. He indicated that she needed a great deal of emotional support.

In spite of efforts to establish the diet, the homemaker-home health aide found her eating salted fish, bok choy, and similar food, since she could not understand the relationship of her diet to her physical

烹飪

Cooking

condition. She needed constant follow-up to keep medical appointments, and equally constant follow-up with respect to medication and diet. Routine personal care in her own room was established since it was decided that the use of the community bath was indeed dangerous for her.

For some time she continued to fear the people upstairs, she insisted that they had bored a hole in the ceiling, were stealing electricity from her and were in other ways attempting to drive her from the building. The social worker gradually encouraged her to meet the neighbors upstairs, and, although her paranoia occasionally recurred, she developed a kind of relationship with them.

She was provided with a cane and was encouraged in gait training. She needed persistent supervision because she would suddenly decide to stop taking her medication. The social worker emphasized that her homemaker-home health aide must not be changed, and she developed a relationship with the aide. There was gradual but steady effort to develop her interest in the Senior Center, since she had no friends in Chinatown and saw her daughter only once a month.

By May 1969 the following comment appears in the record: "Mrs. C. has developed a strong interest in the Senior Center, she has become ambulatory with a cane, her social life is greatly improved, she has gained weight, and a note was added, "purchased wig and hat for Mrs. C."

In December 1969, Mrs. C was moved into a Senior Citizens' Housing Project with private bath and electric stove. She was described as delusional occasionally but more relaxed, and the physician commented that she needs someone to listen to her when she has suspicions about people taking things. The homemaker-home health aide routinely double checks her lock and door.

Home visit, January 1970: "Mrs. C was up and about, dressed very neatly and ready to go to a party in the building. She seemed relaxed and pleasant. She sees her daughter every two months and does her own personal care. Service has been reduced to once a week, primarily for emotional support and general supervision. Although she seems to have variable periods of mild hallucination, she seems to be enjoying life otherwise. Her physical condition is greatly improved, she has a good appetite, and service will be continued on a maintenance basis."

Mrs. C. P. K. F.

This 63 year-old woman was referred to the service by Chinese Hospital, prior to discharge in September 1969. She and her husband immigrated from Hong Kong several years ago. Her husband was a teacher in China and the couple has eight children, all of whom live in other cities. Mr. F had been going to school every morning to study English and was working as a restaurant helper in the evenings.

Mrs. F's diagnosis was CVA with right hemiplegia. When she was visited in the hospital, she was completely bedfast, incontinent, both for bladder and bowel function, profoundly depressed. Her husband, who was obviously devoted to her, was very apprehensive, and the comment was made, "He will need a lot of support."

A plan was established for bed bath, shampoo and passive exercises with the objective of eventually reestablishing ambulation and supporting the restoration of maximum function in activities of daily living. Care was to be daily.

The record for this woman and her elderly husband over a period of two years is the record of a persistent and concerned approach and a well-planned attack to achieve treatment goals. We see the encouragement to attempt passive exercises, the progress from bed to chair, the bowel and bladder training, a move to better housing where toilet facilities are private rather than shared, and where the availability of an elevator held out the prospect of movement out of the house.

We see the establishment of ambulation with short leg braces and a quadraplegic cane, assistance in moving about the apartment, and finally, assistance in outside ambulation.

The physician's comments: "She is making excellent progress in all areas." "We have obtained a wheel chair for Mrs. F." "Mrs. F has begun to follow range of motion exercises with interest."

Then, as her physical situation seems to improve, there is a period of profound depression and persistent efforts by the social worker to encourage and support her.

The quotations continue: "Mrs. F can manage a few stairs with help." "Mrs. F is completely independent in ambulation indoors." Mrs. F walks without a cane for half a block." "Mrs. F now uses the kitchen and stands at the stove for more than 20 minutes." "Mrs. F is independent in most activities of daily living." "Mrs. F dresses herself and can get in and out of the tub with minimal assistance." "Mrs. F attends church every Sunday." And there is a comment from the physician: "Much of the credit for the patient's recovery should go to her husband and to Mrs. K, the homemaker-home health aide of the San Francisco Homemaker Service, who followed a very structured and extensive daily program of support, physical activity and exercises."

In the course of this two-year program, the services of the social worker, the nurse, the physical therapist, the occupational therapist, the nutritionist, and the homemaker-home health aide were coordinated in a progressive program which assisted this family,[5] using the homemaker-home health aide as the focal person. All personnel except the occupational therapist and the physical therapist were Chinese-speaking; the record is one of sustained involvement, utilizing a sensitive, intelligent, and concerned homemaker-home health aide throughout as the key person in the program.

The fact that a tightly-coordinated Chinese staff provided the services accounts almost entirely for the excellent results in what was initially a situation with a poor prognosis.

REFERRALS AND SERVICE

Referrals

Slow beginnings are usually the rule when new service territory is developed. Since the new territory in this instance was so traditionally fixed in its isolation from established community resources, the most guarded and gradual acceptance of home health services by the Chinese population was anticipated.

[5] Kitchen and bathroom in the initial apartment were modified with equipment planned by the staff and obtained by the agency. The transfer to a housing project, where better facilities were available, was prepared for and accomplished with the program established for Mrs. F.

It soon became evident that this expectation would not be supported by fact. Referrals came immediately and at a rapidly accelerating rate, almost from the day of employment of the first Chinese-speaking worker. New referrals in 1967—the first full year of service by the Chinese unit—totalled 85, and continued at this rate through 1971. (Except for 1968 when there was a period of financial retrenchment in the agency.)

A total of 419 Chinese referrals came to the agency during the period of this review (late 1966 through 1971), representing 527 individuals. (Data in this review cover the "referred family member." Agency policy, however, extends services to all members of the household who may effctively utilize services under the initial plan of care.) Acceptance for service of Chinese referrals was twice as high as acceptance in the agency's non-Chinese population. Two-thirds of the Chinese referrals were accepted. Almost all homemaker-home health aide programs accept about one-third of their referrals, and this pattern has been fairly consistent in the San Francisco agency. This rate of acceptance was, as might be expected, caused by the years in which no resources had been available and to the consistent story of shocking neglect in correctible situations, which appeared in the referral histories. The reasons for *not* providing service also differed considerably from those in the general agency population. The agency classifies as reasons for not providing services those referrals which are properly the responsibility of other agencies; those in which the level of service is "beyond agency policy"—i.e., 24-hour service; services unrelated to home health or requiring care which is not feasible in the home environment; and "other"—usually an inquiry which is for information only or the development of other plans either by the applicant or by others. This category "other," in the general caseload, accounts for slightly more than one-half of the referrals for which service is not provided. Of the Chinese referrals, however, slightly more than two-thirds of those *not* provided agency services fell into this "other" category. In this group almost 25 percent of the families refused service, stating as the reason that "they did not want a strange person," and in almost an equal percentage this reason was implied. In another 15 percent other plans were made on an emergency basis by the agency staff at the point of intake: either immediate hospitalization or immediate admission to a 24-hour facility. A number required services unrelated to home care—usually access to other services such as public assistance, clinic care, etc. The staff of the unit almost invariably made the necessary arrangements and did the necessary followup. Agency staff also, at the point of intake, found full-time and live-in attendants in the Chinese population where this was the service required.

The Families

Slightly more than one-half of the Chinese population of San Francisco is male. This pattern is also reflected in the referrals for service: about

護士服務

Nursing

55 percent of the referrals accepted for service were male.

This is in marked contrast with the consistent pattern in the general agency population. Of general agency referrals, 75 percent are for women. This ratio of males to females is even more striking when age groupings are considered. The major age group served by the agency over the years has been the 65 to 79 category (in 1966 slightly more than one-half of the accepted referrals were in this age range) and slightly more than three-fourths were women. In Chinese accepted referrals in the same age grouping, this ratio was reversed; in Chinese referrals in this same age group there was almost a 50-50 ratio of women to men.

This sex distribution is related to the pattern of immigration of Chinese to the United States, which initially stressed male immigration for reasons related to the economy and prejudice of the host country. The final result—a group of helpless, elderly Chinese men, living in isolation and acute discomfort—became the problem which the agency attacked.

Living Arrangements

In the general agency, population living arrangements of the referred family member are classified as "living with spouse," "living alone," "living

with other adult relatives," and "other arrangement." This classification could not be made in referrals for the Chinese population, since relationships were difficult to determine. Individuals lived with others of the same family name, not necessarily related in the Western sense of the nuclear family; there were sometimes teenage and young adults "living" with elderly grandparents, without parents of the appropriate age in the unit; there were more frequently situations in which two or more elderly Chinese lived together because of housing and economic problems without the ties of either blood or friendship as the basis for the arrangement. The fact that individuals are recorded as living "with others" does not, therefore, imply support of a family group.

Living arrangements in the Chinese population were simply classified as "alone" or with others." It could not be assumed that the protective elements of family or friend exist in the latter group.

Two-thirds of the accepted referrals in the *general population* served by the agency represent persons living alone, with women outnumbering men consistently. In the 65-and-older groups in the *non-Chinese population* more than half of those living alone were women. In the Chinese referrals those "alone" in the literal sense represented only about one-half of the total group, but again, men in this older age group who lived alone, including those aged 90 and over, substantially outnumbered women.

The Presenting Problem

As in all in-home service agencies, the primary presenting problem is illness; the agency's traditional emphasis upon services to the adult population has tended to encourage adult referrals and diagnostic problems associated with aging have been the primary presenting problems in referrals received. Chinese referrals in the younger age groups (less than 64 years of age) presented a wide variety of presenting problems: child care during the mother's confinement, fractures, severe nutritional problems, respiratory problems, post-surgical care for acute conditions, diseases of the digestive tract (gall stones, ulcers), malignancies. In the older age group the pattern of multiple, major disabilities appear as they do in the general agency population: heart disease, hypertension, and cerebro-vascular accidents present the largest grouping. Individual case review as well as objective data show an important difference in agency policy with respect to CVA's in the Chinese population, namely acceptance of the Chinese patient with even very severe problems, wherever possible, in view of the great difficulty in making acceptable plans for other care. The records show the most remarkable ingenuity, investment of time and of effort, with equally remarkable results in many of these situations. Diabetes, in the accepted referrals, appears much more frequently in the Chinese population (21 percent of accepted referrals in the Chinese population, 10 percent in the general agency population). The third major category for the Chinese population was cancer. Arthritis and rheumatism

活動療治專家服務

Physical Therapy

were not so frequently reported, but it should be stressed that, during these years, referrals were made for what might be considered only the most urgent, the most catastrophic problems.

The effort to provide care in situations which might have been referred elsewhere, if there had been an "elsewhere" for these drastically ill individuals, make comparisons with the general agency population very difficult. Agency policy in the Chinese unit was applied with the greatest elasticity, and produced ample evidence that a good deal more can be provided in the home in the way of effective service than is normally considered possible.

The Pattern of Service

The Chinese-referred family members along with members of household units who were in need of simultaneous services, frequently for equally serious problems, received more than 130,000 hours of homemaker-home health aide service during the period reviewed. This figure does not include professional visits for assessment and care by nurse, social worker, occupational therapist, physical therapist; speech, nutrition, and field service workers. It does not include professional visits for assessment, planning, and follow-up

when referrals were *not* accepted for service. "Visits," with respect to professional staff, do not present the total picture of planning, searching for referral sources, conferences, and other coordinating efforts. Staff reports indicate that the investment of professional time was probably twice as high for the Chinese population as for the general population.

The pattern of homemaker-home health aide service established at intake provided service for more than three days a week in more than one-third of the scheduled service plans for the Chinese referrals, as compared with one-fourth in the general agency population. More than one-fourth of the Chinese referrals received substantial service twice weekly (in a proportion similar to the non-Chinese population); one-third of the Chinese referrals received once weekly service compared with almost one-half in the general agency population. Length of service was not tabulated. (When a random selection of cases was reviewed, long-term sustaining service for two or more years once weekly appeared to be prevalent.) Slightly more than 10 percent of the referrals were accepted for professional service (usually nursing care) only; supportive services in these situations were provided by others in the household.

It is difficult to draw conclusions concerning the Chinese population served by the agency during the first five years of the service except for the single conclusion that the services were provided to a selected group—selected by the urgency of need and long neglect. The prevalence of elderly, very sick individuals, particularly of single men living in isolation and without care or human contact, is what is most striking in the case review. Conclusions about the special needs of this group if they are significantly different from those of other groups of older sick individuals could be drawn only after the needed community services which are now being established have been available to the Chinese population in adequate quantity over a long enough period of time. The major conclusion is obvious: the crisis approach must be replaced by on-going care services with emphasis on prevention in other areas as well as in health care.

What Was Achieved

"There is no question that the delivery of services in the home by the agency opened up Chinatown in some very important ways."

"Lots of things have happened to improve the health services in Chinatown. But we were there *first*. And we paved the way."

The first statement was made by the Health Officer in District IV. The second by the agency's first Chinese social worker. When his statement was repeated to the health officer, she agreed.

The achievements in terms of volume and range of services, where there were no services before, are important. It is more interesting to see them in human terms and in terms of cultural changes as they affect the future of the population.

In human terms there is the example of an elderly Chinese man who had not left his room for six years and is now walking the crowded streets of Chinatown. More generally, two important changes have taken place. The "opening up" process, the development of an accepted and fuctioning channel to health care for the Chinese, is now being sustained through relationships to the agency's services and to newly developed health and social resources in the area. There is now a free clinic in the area and an outpatient department in the Chinese Hospital, and 27 new agencies have been initiated since 1965. The second and equally important development is the effect of a demonstration of effective services delivered in the home upon current and future plans in Chinatown. New services adapted to the provision of care within the area will be expanded through the recently funded An Lok project which will become a combination of in-home-services, extended care facility, and acute care services in a coordinated service group within the area. Within this complex, the home health agency will function as one of the basic units of care, care which, despite the limitations of miserable housing, economic deprivation, and complex health problems, has been acknowledged as effective and acceptable in the Chinese community.

The key elements in the success of the services are best described by agency staff:

"The women mostly came from different backgrounds than their clients. They were mostly middle class. But they needed the work and the money and this was the only related field they could go into. They needed a lot of education and support but after they began to understand the work they were the ones who knew the problems of the people. Communication had been the biggest problem and now that wasn't a problem any more.

"The clients needed a lot of education, too, about medical care and food and how to get services. But they felt more comfortable. They would really tell the homemakers what their problems were. . . .

"We did a great deal of health education and intervention. We really believe that this population gets better at home. They have their own food and they don't have to go to a strange place far away. . . .

"There was a much better acceptance of health care. They were willing to go to the doctor after a while. . . .

"There was motivation for other things, too . . . not only for health care. They were willing to join with groups . . . to go out . . .

"Some of the fear, Westerners don't understand. There is a fear of disease, a fear of communicability. This affected family support—and we got more of that support when they understood. . . .

"When we began to develop the team work approach the doctors, particularly the younger doctors in Chinatown, became aware. They got interested. . . .

"Home Health was the first to bridge the health care gap in Chinatown in a way they could accept.

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"The only problem is the money thing. They need a lot of services. And money has the biggest priority. . . ."

"The money thing" is indeed a problem. Since 1968 the agency has been forced to reduce its service drastically—those in Chinatown along with those in the whole community. The effectiveness of services in the home have been demonstrated but are still poorly supported.

The development of services to the Chinese population, despite financial limitations, has been rewarding and valuable lessons have been learned:

If a single significant decision in the development of the services were to be identified, it would undoubtedly be the decision to start with Chinese staff, in Chinatown, providing the necessary support and sustaining an attitude of willingness to learn from both staff and consumers. While this appears to be a simple and obvious conclusion, it was not so simple in the implementation of the service. It involved reliance on the key bilingual professionals to transmit *all* aspects of agency service—policy, objectives, personnel practices, and service philosophy, to a group of workers who could be reached *only* through those professionals. It involved a great effort in the adaptation of training programs, materials, and care patterns to the Chinese staff and to the needs of the community and to adapt flexibly to those needs—to stretch policy as far as it would go. It also involved a willingness to join with the emerging elements of the Chinese population—to do the kind of community organization that is so essential to the future of the Chinese community.

The extension of in-home services to Chinatown could never have been undertaken by the agency alone. It received a great deal of support from the Health Department of San Francisco, particularly the District IV Health Center staff; from the Council of Churches and Cameron House; and from the unusually effective staff of the Economic Opportunity Committee-funded Self Help for the Elderly. The An Lok project, of which the home health agency is a part, and the efforts which are being made by a new and aggressive Chinese communal approach are only a beginning, but such beginnings offer the best hope for the future of the Chinese community.

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U. S. GOVERNMENT PRINTING OFFICE : 1973 O - 506-189